



Prior Authorization Request Form

Dell Children's HealthPlan prior authorization: **1-855-962-4453** (phone); **1-844-981-3329** (fax).
 To prevent a delay in processing your request, please fill out the form in its entirety with all applicable information.

Today's date:		Provider return fax:	
Member information			
First name:	Last name:	Date of birth:	
Dell Children's Health Plan member ID:		Contact phone:	
Address:	City, State ZIP code:		
Additional member information:			
Referring provider		Participating: <input type="checkbox"/>	Non-participating: <input type="checkbox"/>
Full name:	NPI:		
Specialty:	Provider ID:		
Tax ID number (TIN):	Office contact name:		
Office phone:	Office fax:		
Address:	City, state ZIP code:		
Servicing provider		Participating: <input type="checkbox"/>	Non-participating: <input type="checkbox"/>
Full name:	NPI:		
Specialty:	Provider ID:		
Tax ID number (TIN):	Office contact name:		
Office phone:	Office fax:		
Address:	City, state ZIP code:		
Servicing facility		Participating: <input type="checkbox"/>	Non-participating: <input type="checkbox"/>
Name:			

NPI:		Provider ID:	
Tax ID number (TIN):		Facility contact name:	
Facility phone:		Facility fax:	
Address:		City, state ZIP code:	
Requested service (for type of service, check all that apply)		Date/date range of service:	
ICD-10 code(s):			
CPT® code(s) (include requested units/visits):			
Modifier(s):			
Type of service:	<input type="checkbox"/> Outpatient <input type="checkbox"/> Planned inpatient <input type="checkbox"/> Emergent inpatient <input type="checkbox"/> Skilled nursing facility <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> Long-term services and supports/long-term care <input type="checkbox"/> Home health <input type="checkbox"/> Durable medical equipment <input type="checkbox"/> Ambulance <input type="checkbox"/> Diagnostic study <input type="checkbox"/> Hospice <input type="checkbox"/> Office visit <input type="checkbox"/> Personal care services <input type="checkbox"/> Other: _____		
Place of service:	<input type="checkbox"/> Hospital <input type="checkbox"/> Ambulatory surgery center <input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Independent lab <input type="checkbox"/> Nursing facility <input type="checkbox"/> Other: _____		
Additional information:			

Please submit all appropriate clinical information, provider contact information and any other required documents with this form to support your request. If this is a request for extension or modification of an existing authorization from Dell Children’s Health Plan, please provide the authorization number with your submission in the Additional Information section.

Emergent—Use for **all** non-elective **inpatient** admissions only, when the provider indicates that the admission was urgent, emergent or expedited (for admission on the same day).

Urgent—Use for **outpatient** services only, when provider indicates that the service is urgent, emergent or expedited